North East **LHIN** | **RLISS** du Nord-Est

North East Local Health Integration Network

2014/15 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Cover Photo: Monica Bretzlaff, BSO Provincial Manager (left), and Nurse Practitioner Shannon Cadieux (right), facilitate a Montessori-based dementia activity with Gert. The NE LHIN has invested in specialized training for more than 70 front-line workers, BSO training for another 7,500 practitioners already working in the field to provide older adults with the care they need, and coaching for families and staff on strategies to help prevent and respond to responsive behaviours. Four integrated BSO response teams are based in community, hospitals, tertiary care and LTCHs within Northeastern Ontario (Sudbury-Parry Sound-Manitoulin, Nipissing-Temiskaming, Cochrane and Algoma). Focused on enhancing care and capacity, these teams are also linked with key medical and psychiatric specialists who serve as instrumental change agents.

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ISSN 1911-2955 Annual Report 2014-2015, North East Local Health Integration Network.

Message from the Board Chair and CEO

June 30, 2015

This second year of our 2013-2016 Integrated Health Service Plan (IHSP) has been spent advancing our priority areas.

Louise Paquette, Chief Executive Officer

Developed with the input of more than 4,000 Northerners, our IHSP outlines four priorities to enhance the regional system of care: increase access to primary care; strengthen transitions of care as Northerners move from one part of the system to another; make mental health and addictions services more accessible; and target the needs of Francophone and Aboriginal/First Nations/Métis people living in Northeastern Ontario. These priorities are supported by three enablers: technology, system realignment, and health human resources.

We've spent a good part of this past year engaging and learning from fellow Northerners. We've talked to patients, health service providers, caregivers and municipal leaders about our health care goals and the collaborative work needed to meet them. We've also asked Northerners to look ahead towards our next IHSP (2016-2019) and provide their input into how we can hold the gains on what we have achieved while renewing our priority areas to continue to strengthen the Northeastern Ontario health care system.

Danielle Bélanger-Corbin, Board Chair

This Annual Report speaks to the progress made with our many partners – both within health care and beyond over the past year – including:

- Supporting new geriatric assessments and care plans, along with diabetes assessments and foot care, for Elders along the James and Hudson Bay Coast
- Launching our publication, *Community Hospitals and Health Care in Northeastern Ontario – Transforming the Patient Experience*, which chronicles the historic role of our region's 20 community hospitals and looks to what future role they could play in strengthening community care
- A new 'made-in-the-North' non-urgent transportation model, which addresses issues such as stranded patients and escorts, delayed rides into and out of large hospitals, patient flow and repatriation challenges
- A Regional Pharmacy Initiative, which is enabling hospitals to enhance quality of care for patients through the reduction of medication errors and increase in care coordination
- Preventing falls by seniors with a unique Stay On Your Feet collaboration with the region's five public health units, combined with funding 177 exercise classes and 111 falls prevention exercise classes
- Implementing recommendations from our in-depth analysis of the North East Community Care Access Centre to ensure Northerners' needs are met in community or at home
- A Vision Care Plan to share best practices, address recruitment and retention challenges, and meet the eye care needs of Northerners today and into the future
- New housing models and transition supports for people with mental health and addictions issues
- More assisted living for high risk seniors

As the NE LHIN moves forward, we will continue to engage with Northerners and invite them to be part of the important conversation to improve health care in Northeastern Ontario.

Danielle Bélanger-Corbin, Board Chair

Louise Paquette, Chief Executive Officer

Welcome to the NE LHIN

Mission

To advance the integration of health care services across Northeastern Ontario by engaging our local communities.

« Favoriser l'intégration des services de santé dans le Nord-Est de l'Ontario en engageant nos communautés locales. »

Enkiichigaadeg waazhi maajiishkaang maamwizwin eni zhischigaadeg wii minoyaang naadmaadwin. Giiwednowaabnong nikeya dinokiiwning ni zhischigaadeg wii minwaabminaagog endnokiishnang

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Vision

Quality health care, when you need it.

Des services de santé de qualité au moment voulu.

Ezhi gshkitoong go waani zhi mino yang naadgo wendming pii ndo wendaagog.

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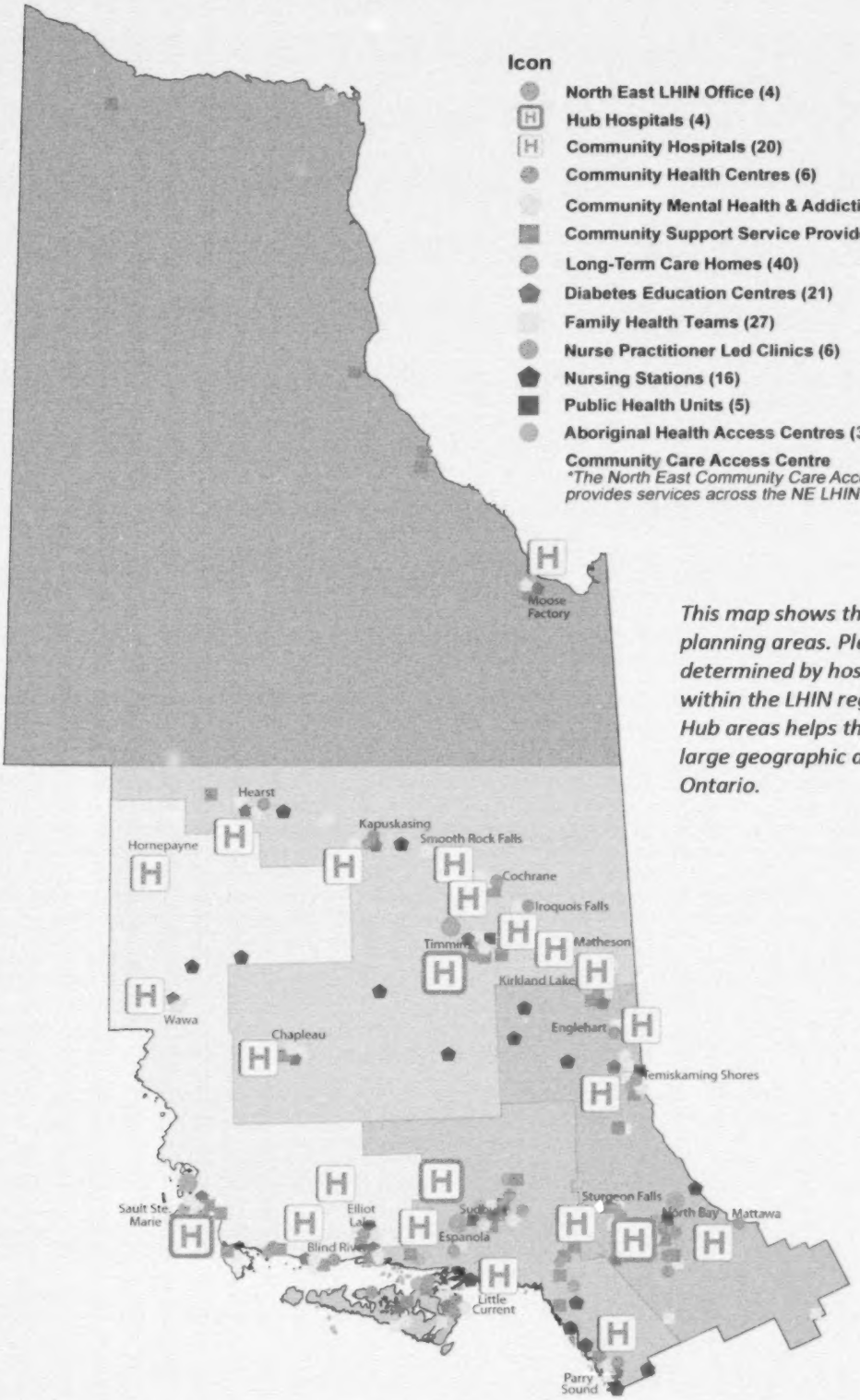
Senior Denise Parry is one of the many Northerners who want to live in their own home and stay as healthy as possible, for as long as possible – both physically and mentally. Denise benefits from LHIN-funded exercise classes for seniors in her home city of North Bay. Currently, 20% of people living in Northeastern Ontario are over the age of 65. This number is expected to swell to 26% by 2025.

The NE LHIN Region



This map shows the NE LHIN's "Hub" planning areas. Planning areas have been determined by hospital referral patterns within the LHIN region. The designation of Hub areas helps the NE LHIN manage the large geographic area of Northeastern Ontario.

NE LHIN Facts, Stats and Figures

Geography:[1]

- Second largest LHIN, with approximately 400,000 square kilometres – 44% of Ontario's land mass.

Demographics:[2]

- Home to an estimated 565,000 people, or 4.1% of Ontarians in 2015.
- Declining population – 1.5% decline over the last 10 years, compared to a 10.2% provincial population increase. The Northeastern Ontario population is projected to decline by 1% over the next 10 years.
- Older population – 20% of people are aged 65+, as compared to 16% for Ontario. This percentage is expected to increase to 26% by 2025 (compared to 21% for Ontario).
- Culturally diverse – approximately 11% Aboriginal[3]; 23% Francophone[4].

Health Service Providers:

The NE LHIN funds 144 health service providers (HSPs) within six sectors; some organizations provide services in more than one sector and would be counted in each sector below:

- Hospitals (25 – includes a complex continuing care centre)
- Community Health Centres (CHCs) (6)
- Community Mental Health & Addictions (46)
- Community Support Services (CSS) (67)
- Long-Term Care Homes (LTCHs) (40)
- Community Care Access Centre (CCAC) (1)

Health Care Services:

- 303 physicians working in 52 physician groups providing comprehensive primary care, including Family Health Organizations, Family Health Groups, Family Health Networks, Rural Northern Physician Group Agreements and a Group Health Centre.
- 27 family health teams (FHTs), six CHCs, six nurse practitioner-led clinics (NPLCs) 16 nursing stations and three Aboriginal Health Access Centres (AHACs).[5]
- The Health Care Connect Program is helping Northerners better connect with primary care providers. From February 2014 to February 2015, the percentage of patients successfully connected to a primary care provider remained stable at 78%.
- 105 (LTC) beds for every 1,000 people aged 75 and over (2015), as compared to 82 beds per 1,000 people aged 75 and over in Ontario.[6] There are 5,546 LTC beds across the region (highest supply of LTC beds per capita).

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[1] *Statistics Canada – 2011 Census*
[2] *Populations, Ontario Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO. Last refreshed September 2014*
[3] *Statistics Canada – NHS Aboriginal Profile, 2011*
[4] *Data provided by Department of Francophone Affairs, January 2015*
[5] Ontario GPs (2015-02-25), Health Analytics Branch, MOHLTC
[6] Ministry of Health and Long Term Care, Health Data Branch Portal, Long Term Care Homes Report and *Populations, Ontario Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO. Last refreshed September 2013*

Health Facts:

- NE LHIN residents have a shorter life expectancy than residents of Ontario: 76.5 years for males (79.2 years in Ontario), and 81.4 years for females (83.6 years in Ontario).[7]
- Premature mortality, a measure of death rates (per 100,000 population) prior to age 75 is 35% higher in the NE LHIN when compared to the province.[8]
- The leading causes of death for NE LHIN residents, as well as all Ontarians, are circulatory system diseases (such as heart disease and stroke) and neoplasms (cancer). The rate of circulatory system disease deaths (per 100,000 population) is 22% higher in the NE LHIN than in Ontario and neoplasms are 16% higher.[9]
- Poor health practices are related to an increased risk of chronic disease, mortality and disability. NE LHIN residents are more likely to smoke and more likely to drink heavily. They are also more likely to be overweight or obese – 60% compared to a provincial rate of 53%.[10]
- There is a higher percentage of people living with chronic diseases than the rest of Ontario, including:[11] arthritis/rheumatism – 25% vs.17%; and asthma – 9% vs. 8%.
- A recent study by the Ministry of Health and Long-Term Care (MOHLTC) showed 14.3% of residents 18 years of age and older are living with diabetes. This compares to a rate of 11.9% for the province.[12]

Edith Mercieca (left) of the N'Mninoeyaa Community Health Access Centre, Louise Paquette, CEO of the NE LHIN, and the Provincial Seniors Care Strategy Lead, Dr. Samir Sinha, stop for a photo before the start of a First Nations Community Support Service Summit in Sudbury. More than 100 providers from across the region gathered to talk about forging new partnerships, caring for Elders in a way that respects and acknowledges culture, as well as ways to work together to create new pathways so that patients and families come first, regardless of where they live in Northeastern Ontario.

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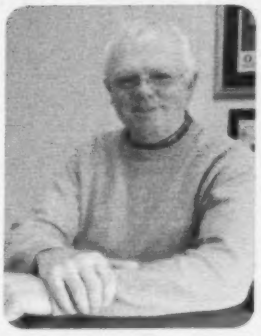
[7] *Statistics Canada, Health Profile, December 2013*
[8] *Statistics Canada, Health Profile, December 2013*
[9] *Statistics Canada, Health Profile, December 2013*
[10] *Statistics Canada, Health Profile, December 2013*
[11] *Statistics Canada, Health Profile, December 2013*
[12] *Key Performance Measures for the Ontario Diabetes Strategy, Health Analytics Branch, Ministry of Health and Long-Term Care (June 2014)*

NE LHIN Board of Directors

Our Board of Directors is an active board with engaged and committed members who bring a wide variety of expertise to the governance table including accounting, medicine, and management, as well as palliative and geriatric care. Directors bring the face of the communities we serve to our decision making, and as we seek new board members, this breadth of skills and expertise continues to be sought.

Danielle Bélanger-Corbin, Chair
Temiskaming Shores

Term: September 29, 2010 to September 29, 2013; renewed to September 28, 2016



Rick Cooper, Vice Chair
Kagawong, Manitoulin Island

Term: October 23, 2013 to October 22, 2016

Dawn Madahbee
Manitoulin Island

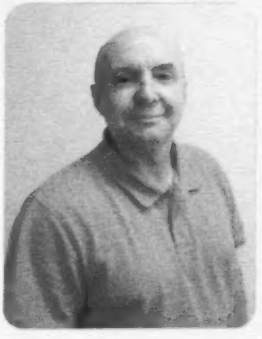
Term: September 8, 2014 to September 8, 2017

Santina Marasco
Sudbury

Term: August 15, 2012 to August 14, 2015

Dr. Colin Germond
Sudbury

Term: April 21, 2010 to April 21, 2013; renewed to April 20, 2016



Denis Bérubé
Moonbeam

Term: November 5, 2014 to November 5, 2017

Toni Nanne-Little
Sault Ste. Marie

Term: February 11, 2015 to February 11, 2018

Board Advisory Committees

Our Board of Directors has two advisory committees: Health Professionals Advisory Committee (HPAC) and Local Aboriginal Health Committee (LAHC). Both committees meet face-to-face twice each year and provide system-level advice to the Board.

Health Professionals Advisory Committee (HPAC)

HPAC serves as a collective voice for health professionals and has the important responsibility of providing advice to the NE LHIN Board on: how to achieve patient-centred health care and further develop the leadership role of health professionals in promoting integrated health care delivery; effective ways and means to move forward with the priorities of the NE LHIN's strategic plan (IHSP); and considerations in the development of integrated models of care across Northeastern Ontario.

HPAC Members:

- **Roger Pilon (Chair)**, Laurentian University Faculty and Nurse Practitioner, Centre de santé communautaires du grand Sudbury
- **Diane Stringer (Vice Chair)**, Director of Care, South Centennial Manor, Cochrane
- Allyson Campsall, Registered Practical Nurse, Temiskaming Hospital
- Deb Hill, Vice President of Patient Care & Chief Nursing Executive, Weeneebayko Area Health Authority (WAHA), Moose Factory
- Maria Coccimiglio, Pharmacist, Sault Area Hospital
- Stephanie Doni, Dietitian, Sudbury District Nurse Practitioner Clinics
- Renée-Ann Wilson, Advanced Practice Physiotherapist, North East Joint Assessment Centre
- Jennifer Fournier, Nurse Practitioner, Director, Capreol Nurse Practitioner Led Clinic
- Dr. Albert Gouge, Clinical Psychologist, Health Sciences North
- Dr. Tara Leary, Physician, Health Sciences North and Shkagamik-Kwe Health Centre, Sudbury
- Sandra Linton, Manager, Temiskaming Home Support
- Dr. Emmalee Marshall, Vice President, Medical Affairs, Sault Area Hospital
- Dr. Al McLean, Physician, Superior Family Health Team, Sault Ste. Marie
- Pam Williamson, Executive Director, Noojmowin-Teg Health Centre, Little Current
- Dr. Colin Germond, Director, NE LHIN Board
- Louise Paquette, Chief Executive Officer, NE LHIN (ex officio)

CEO Louise Paquette and Roger Pilon, Nurse Practitioner and HPAC Chair, engage HPAC members in a discussion of home and community care in Northeastern Ontario. HPAC members represent different health professions, health sectors, and geographical areas of the NE LHIN region, while providing system-level advice and input into advancing the NE LHIN's four priorities.

Local Aboriginal Health Committee (LAHC)

The LAHC advises the NE LHIN Board on health service priorities within Aboriginal (First Nations, Métis, urban, rural) communities, as well as on opportunities for the integration and coordination of health care services. The LAHC and the NE LHIN work collaboratively to identify targeted engagement activities that will lead to outcomes that support enhancing access to care for Aboriginal people living in Northeastern Ontario.

LAHC Members:

- **Gloria Daybutch (Chair)**, Executive Director, Maamwesying North Shore Community Health Services, Cutler
- Rachel Cull, Interim Executive Director, Misiway Milopemahtesewin Community Health Centre, Timmins
- Dale Copegog, Director of Health and Social Service, Wasauksing First Nation, Parry Sound
- Sally Dokis, Health Director, Dokis Health Centre, Monetville
- Julie Morin, Operational Director, Mnaamodzawin Health Centre, Little Current
- Giselle Kataquapit, Health Director, Peetabeck Health Centre, Fort Albany
- Veronica Nicholson, Executive Director, Timmins Friendship Centre, Timmins
- Angela Recollet, Executive Director, Shkagamik-Kwe Health Centre, Sudbury
- Janice Soltys, Chief Information Officer, WAHA, Moose Factory
- Mary Jo Wabano, Health Services Director, Wikwemikong Health Centre, Manitoulin Island
- Pam Williamson, Executive Director, Noojmowin-Teg Health Centre, Little Current
- Dawn Madahbee, Director, NE LHIN Board
- Louise Paquette, Chief Executive Officer, NE LHIN (ex officio)

Gloria Daybutch, LAHC Chair (left), and Dawn Madahbee, NE LHIN Board Member, contribute to LHIN efforts to make meaningful changes in the way Northerners receive health care services, particularly recognizing our region's cultural diversity. The LAHC advises the NE LHIN on health service priorities within Aboriginal communities, as well as on opportunities for the integration and coordination of health care services. The LAHC and NE LHIN work collaboratively to identify targeted engagement activities on the specific needs of Aboriginal populations.

Ministry-LHIN Performance Agreement (MLPA)

The MLPA defines the relationship between the MOHLTC and the NE LHIN in the delivery of local health care programs and services. The MLPA establishes a mutual understanding between the MOHLTC and the LHIN and outlines performance indicators within a defined period of time. Indicators are updated every quarter; for an up-to-date status report on indicators, please contact the NE LHIN or visit www.nelhin.on.ca.

Performance Indicator	LHIN 2014/15 Starting Point	LHIN 2014/15 Performance Target	Most Recent Quarter 2014/15 LHIN Performance	FY 2014/15 LHIN Annual Result
Access to health care services				
90th percentile ER length of stay for admitted patients	29.12	25	35.78	32.22
90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	6.5	6.5	5.53	5.57
90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.13	4	3.85	3.95
Percent of priority IV cases completed within access target (84 days) for cancer surgery	92%	90%	93.69%	87.43%
Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	93.8%	90%	97%	99%
Percent of priority IV cases completed within access target (182 days) for cataract surgery	98%	90%	92.12%	91.11%
Percent of priority IV cases completed within access target (182 days) for hip replacement	77%	85%	82.18%	76.14%
Percent of priority IV cases completed within access target (182 days) for knee replacement	61%	75%	77.70%	71.52%
Percent of priority IV cases completed within access target (28 days) for MRI scans	68%	80%	43.43%	47.34%
Percent of priority IV cases completed within access target (28 days) for CT scans	75%	83%	68.92%	71.27%
Integration and coordination of care				
Percentage of Alternate Level of Care (ALC) days – by LHIN of institution*	22.33%	22%	22.58%	22.56%
90th percentile wait time for CCAC in-home services – application from community setting to first CCAC service (excluding case management)*	59	48	76	76
Quality and improved health outcomes				
Readmission within 30 days for selected CMGs*	16.96%	15%	19.64%	18.74%
Repeat unscheduled emergency visits within 30 Days for mental health conditions*	17.2%	16.5%	18.17%	17.24%
Repeat unscheduled emergency visits within 30 days for substance abuse conditions*	27.2%	25%	30.65%	29.42%

*FY 2014/15 is based on most recent four quarters of data (Q4 2013/14 - Q3 2014/15) due to availability.

Report on MLPA Performance Indicators

Emergency Room (ER)

ER performance is monitored on three key indicators including the 90th percentile length of stay (LOS) for admitted patients, the 90th percentile LOS for non-admitted complex patients, and the 90th percentile LOS for non-admitted minor uncomplicated patients.

Admitted patients: At 32 hours, overall performance in 2014/15 did not meet target (25 hours). Patients waiting to be admitted to the hospital were delayed by system challenges, particularly in Sault Ste. Marie where alternate level of care (ALC) patients occupying acute beds reached levels that slowed the regular flow of patients from the ER to inpatient units. In Sudbury, an unexplained increase in ER visits contributed to higher volumes of admitted patients to acute beds at full occupancy. Daily high numbers of patients waiting in the ER for admission to hospital also contributed to increased LOS. Progress is being made in Sault Ste. Marie in terms of reducing the number of ALC patients occupying acute beds through such initiatives as opening 50 new interim long-term beds in May 2015.

High Acuity non-admitted patients: At 5.6 hours, the NE LHIN more than met the target (6.5 hours), as hospitals were able to assess, treat and discharge complex patients in less than 6 hours. Complex patients often require tests and interventions prior to discharge and overall, hospitals performed very well.

Low Acuity non-admitted patients: At 3.95 hours, the NE LHIN met its target. Low acuity non-admitted patients include some ER visits that could be managed in other settings such as community primary care providers – including family doctors and nurse practitioners (NPs) – where there is capacity. The NE LHIN's Primary Care Advisory Council is working on strategies so that Northerners can forgo a trip to the ER for health concerns that can be treated in community.

The NE LHIN supports several strategies to improve ER LOS. These include its Pay for Results Action Plan, which is a focused-performance improvement plan for the four large urban hospitals. Other initiatives such as Geriatric Emergency Management (GEM) nurses support discharge from the ER for frail seniors who need additional assessment and supports after physician assessment is completed. As well, the Emergency Department Outreach Service in Sudbury provides on-call support to residents of local LTCHs by sending ER nurses to the home, which in many cases can prevent a trip to the hospital's ER.

Surgical Wait Times

In 2013/14, wait times reporting for surgical and diagnostic imaging changed from monitoring the 90th percentile wait for surgery/imaging, to a focus on the percentage of priority IV cases completed within access targets. Priority IV cases are generally elective cases or those cases that physicians assess as non-urgent.

Cancer Surgery: In 2014/15, performance fell below target (90%) early in the year but by Q4 had achieved target at 94% as a result of focused improvement efforts. To help optimize wait times, the Northeast Regional Cancer Centre's surgical lead worked closely with all hospitals providing cancer surgery on effective strategies.

Cardiac Bypass Surgery: In 2014/15, 99% of priority IV surgeries were completed within the access target of 90 days. Working closely with the Cardiac Care Network of Ontario, Health Sciences North (NE LHIN's sole provider of heart surgery) maintained an above target performance throughout the year.

Cataract Surgery: In 2014/15, 91% of priority IV cataract surgeries were completed within the target of 182 days. This high demand surgery, in part related to the NE LHIN's aging population, was supported by hospital cooperation in the redistribution of surgical volumes late in the fiscal year.

Hip and Knee Replacement Surgery: In 2014/15, a focused performance plan resulted in improved wait times for patients. By Q4, priority IV hip replacement performance was at 82%, almost meeting target (85%), and priority IV patients receiving knee replacements surpassed target (75%). Both hip and knee replacement surgeries were in high demand with approximately two patients waiting for every available hip surgery, and three for every available knee surgery. The NE LHIN continues to work with partners on strategies to improve performance, including the NE LHIN's Joint Assessment Centres (JAC) (one in each of the surgical centres), which require all potential hip and knee replacement patients to be assessed by an Advanced Practice Physiotherapist who has received specialized training from orthopaedic surgeons. This assessment process gets the right patients to a surgeon and other patients to alternate care options, including additional rehabilitation or other forms of care that reduce or delay the need for surgery. In the NE LHIN, more than 50% of assessments that are completed by the JACs do not result in a consultation with an orthopaedic surgeon.

Diagnostic Wait Times

Magnetic Resonance Imaging (MRI): In 2014/15, 47% of priority IV scans were completed within the access target of 28 days, falling short of the NE LHIN's target of 80%. The NE LHIN ranked fourth in the province and overall, priority IV patients waited 55 days – the second best wait time in the province. All MRI sites demonstrate good efficiency levels and compare well with provincial peers.

Computed Tomography Imaging (CT): In 2014/15, 71% of priority IV scans were completed within the access target of 28 days, falling short of the NE LHIN's target of 83%. High demand for CT scans is a key consideration, in part due to the evolving use of CT for many diagnostic needs.

Alternate Level of Care (ALC)

Patients designated as ALC are those who remain in hospital after the acute portion of their care is completed, but their next destination is unavailable. Their hospital stay is thus prolonged waiting for an "alternate level of care." Altogether, 95% of hospital patients do not accumulate ALC days, but 5% are delayed getting to their next level of care due to system challenges. Overall, the NE LHIN performed well with 22.5% of ALC patients, just above its 22% target in 2014/15. System challenges were particularly acute in Sault Ste. Marie, which had very high numbers of ALC patients awaiting discharge, particularly to LTC beds. It is anticipated that the opening of 50 interim LTC beds in May 2015 will enable discharge of ALC patients and improve patient flow in the Sault Area Hospital. Capacity in the CSS sector is also key to the successful transitioning of patients from hospital, and the NE LHIN continues to invest in key strategies such as assisted living for high risk seniors, behavioural supports for LTC, assess and restore beds, and a commitment to the "home first" philosophy.

Access to Community Care

Providing in-home services for clients in the community is a key program of the North East Community Care Access Centre (NE CCAC). At a wait time of 76 days, the NE LHIN did not meet its target of 48 days in 2014/15. A number of factors contributed to longer waits for community clients including the following:

- Some remote communities lack access to community services such as some therapies (e.g. occupational therapy and physiotherapy) and thus have longer wait lists for service.
- Assessment of clients identifies higher and lower priority needs and those with lower priority needs have longer waits for service, which tends to increase the 90th percentile wait time.
- Service demand increase in the volume of community referrals and the complexity of service needs of clients has placed pressure on nursing resources.

The NE LHIN will continue to work with the NE CCAC to monitor the implementation of the in-depth capacity analysis for the NE CCAC, which was completed in 2014.

Hospital Readmissions and Repeat Unscheduled ER Visits for Mental Health and Addictions

Hospital Readmissions Within 30 days: At 18.4%, the rate of readmissions exceeded the target (15%). Key initiatives by the NE LHIN include: the congestive heart failure clinic and care transitions unit at Health Sciences North, focusing on the patient's journey in hospital and supporting care after discharge; CCAC case managers in selected FHTs who contribute to earlier identification and treatment for the frail elderly; deployment of rapid response nurses to focus on the frail elderly with complex conditions and high risk of readmission to hospital; Telehomecare support for patients with congestive heart failure and chronic obstructive pulmonary disease (COPD); and the implementation of Health Links and other models of care.

Repeat Unscheduled ER Visits within 30 days for Mental Health: At 17.2%, the rate of ER revisits for mental health exceeded target (16.5%). NE LHIN strategies to support people with mental health conditions and reduce revisits include: peer support navigators in ER, mental health case managers in ER, community crisis support/ER diversion, and the implementation of the CritiCall mental health bed registry to support rural hospital access to Schedule 1 beds, and others.

Repeat Unscheduled ER Visits within 30 days for Substance Abuse: At 29.4%, the rate of ER revisits for substance abuse exceeded target (25%). Most communities in the NE LHIN met the 25% target; however, significant challenges exist specifically concerning people with complex and chronic addiction to alcohol who are frequent users of the ER. Initiatives to support people with substance abuse conditions include: supportive housing linked to health services, additional resources for opiate addictions, peer support initiatives, integration of addictions services to improve service delivery, and a focused harm reduction initiative.

NE LHIN Board Chair, Danielle Bélanger-Corbin,with Inspector Rob Jerome from the North Bay Police Service (NBPS) at a community event that highlighted the patient-focused cooperation of mental health and addictions service providers and partners. The launch of a new LHIN-funded Mobile Crisis Service in North Bay is a result of a partnership between the NE LHIN, the North Bay Regional Health Centre and the NBPS that is ensuring early identification of people suffering from a mental health and/or addiction crisis in the community. The unique partnership is providing timely assessment of individuals at risk and earlier intervention to better support the individuals. From September 2014 to March 2015, there has been a 30% reduction in the number of people brought to the North Bay ER under apprehension, more than 250 hours spent serving clients in the community rather than in hospital, and a 50% reduction in time spent by police in the ER.

Community Engagement

Engagement outcomes are considered in LHIN decision making to enhance access to care for Northerners. The NE LHIN engages with hundreds of Northerners every year to seek input on addressing system gaps, and to receive input into improvements that can be made to improve the local health care system. In addition to engagements outlined on the following pages, more than 260 engagements were held in the past year to advance the NE LHIN's strategic plan priorities and strengthen the delivery of health-care services for Northerners.

Recent engagements to enhance the patient experience in Northeastern Ontario included:

- Two patient engagement sessions held in Sault Ste. Marie and North Bay in collaboration with The Change Foundation. About 170 people from across the region participated and learned about programs, services, processes and tools to allow patients to be more involved in health care planning and decision making. Participant evaluation results indicated that 84% of people said they learned at least one strategy for better patient involvement that they would apply to their work.
- Northerners were invited to participate in a 10-question survey late in 2014 on ways to strengthen the regional health care system, with a special focus on home and community care. More than 1,000 people responded. Comments received were shared with a provincial expert panel whose efforts resulted in the milestone provincial report *Bringing Care Home*. In addition, Northerners' input was analyzed in the NE LHIN report entitled *Perceptions on the Northeastern Ontario Health Care System*, which found six themes: access; accountability; coordination and integration; health human resources; communication, education and engagement; and cultural diversity and the Northern perspective. The outcomes of this engagement are now helping to inform the NE LHIN's 2016-2019 IHSP.
- A Virtual Coffee Break held in November 2014 attracted more than 200 Northerners to listen in on ideas for improving home and community care. Provincial Seniors Care Strategy Lead Dr. Samir Sinha, special guest, and Louise Paquette, CEO of the NE LHIN, offered discussion points to listeners.

In total, more than 66 structures (working groups, advisory and steering committees) meet on a regular basis to discuss ways and means to improve access to care in specific touch-points of a patient's care journey. Many of the groups count patients, clients or consumers in their ongoing work.

Ongoing examples of engagement opportunities to help inform the NE LHIN's work include:

- Health Professionals Advisory Committee meetings – members represent a wide range of health care sector professionals across Northeastern Ontario
- Local Aboriginal Health Committee meetings to share information and receive advice on improving access to care for Aboriginal people
- Partnership efforts with the Réseau du mieux-être francophone du Nord de l'Ontario to better support the health-care needs of Francophones
- Regular meetings with HSPs to discuss opportunities for collaboration and integration such as: eHealth Advisory Council, North East Hospice Palliative Care Network, North East Behavioural Supports (BSO) Working Group, Regional Mental Health and Addiction Consultation Group, FHTs, NE LHIN Community Support Services (CSS) Network, and Stay on Your Feet Regional Steering Committee
- IT Integration and Alignment Council (IAC) which includes participation from all 25 hospital CEOs and Chief Information Officers. The Council provides advice and recommends solutions to increase efficiency, standardization, shared purchasing/procurement and interoperability of systems across the region

Hospital Pharmacy Peer Group: *Following a NE LHIN survey of all Northeastern hospital pharmacies to identify challenges and opportunities, 27 pharmacy representatives from across the region met for the first time in March 2015. The group helps Northeastern hospitals to enhance patient safety and quality of care through the reduction of medication errors and enhanced care coordination. The NE LHIN's Chief Information Officer Tamara Shewciw (standing) listens to the discussion of (left to right): Chantal Tessier, Chief Nursing Officer – Smooth Rock Falls; Marc-André Gravel, Pharmacist at MICs Group of Health Services (Matheson, Iroquois Falls, Cochrane); Natalie Roy, Pharmacist Coordinator – Timmins; and Susan Stemp, Pharmacist at North Bay Regional Health Centre.*

- **Regional Steering Committee for Stay on Your Feet (SOYF):** This multi-sectoral committee was established by the NE LHIN in September 2014 to oversee the integrated regional strategy for preventing falls, and to build on local capacity. SOYF is a best practice that promotes healthy active aging and works to prevent falls among older adults in community and health care facilities, including hospitals and LTC facilities.

- **Local Partnership Group:** Co-chaired by a hospital chief nursing officer and the NE LHIN, with representatives from hospitals and the NE CCAC (physician, clinical and financial), this group helps to foster a change management environment at the local level and supports the successful implementation of the Health System Funding Reform. The group has the added responsibility of overseeing the implementation of the NE LHIN's Clinical Services Review to improve patient quality for quality based procedures.

- **Diabetes Advisory Committee:** HSPs, administrators and patients meet eight times a year to improve care coordination, education and prevention of diabetes.

- **North East Regional Community Support Services Network:** Senior leaders from CSS organizations, Francophone and Aboriginal/First Nations/Métis providers work on strategies to help people live independently at home or in community and strive to improve their quality of life.

- **Regional Primary Care Council:** Primary care practitioners meet regularly to help increase system-wide collaboration to better support the patient journey.

- **North East Hospice Palliative Care Steering Committee:** Providers who are involved in delivering palliative care services and education sit on this committee, which oversees the recommendations of implementing the report, *Advancing High Quality and High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action* (2011).

- **Northeast Rehab Complex Care Steering Committee:** Providers representing rehabilitative care programs in the NE LHIN meet regularly to collaborate on rehabilitative care. Planning is aligned with the work of the Provincial Rehabilitative Care Alliance, with the goals of effecting positive change and achieving improved patient outcomes.

Community Engagement with Aboriginal/First Nations/Métis People

The NE LHIN is committed to an engagement process with Aboriginal/First Nations/Métis people that is respectful of language, nationhood, culture and spiritual beliefs.

Aboriginal people represent about 11% of the people living in Northeastern Ontario. The LHIN continues to focus on building meaningful relationships in an effort to improve the services and health status given that the health needs of Aboriginal people are significant in scope and magnitude. Efforts continue to enhance health outcomes by aligning existing Aboriginal/First Nations/Métis regional, provincial and federal health planning and service delivery structures. Among our Aboriginal population, people are aging faster than the rest of the population due to high rates of chronic diseases.

NE LHIN CEO Louise Paquette and Dr. Gordon Green, WAHA Chief of Staff, stopped for a photo during a tour of the Moosonee Health Clinic in February 2015. The temporary clinic has been housed in a local recreation complex following a fire in 2012. A newly built clinic will open in June 2015. Paquette and senior staff from the MOHLTC and Health Canada met with WAHA's senior team and community chiefs, and took part in discussions about ways and means to continue to increase access to health care services for people living in coastal communities.

Engagements held in 2014/15 include:

- **Local Aboriginal Health Committee:** LAHC members travelled from their communities across the region for a full-day meeting in both May and October 2014 with the NE LHIN. Members were briefed on the latest health care developments and were asked for their input on moving forward with strategies to increase access to care for this population group.
- **Coastal communities:** The NE LHIN visited coastal communities in February 2015 to further identify the level of support required for completing performance reports. LHIN staff spoke to people about its work along the coast and engaged on how to move forward with stronger health care for people living in the NE LHIN's northernmost communities. In addition, the LHIN CEO and senior staff engaged with community Chiefs and WAHA senior staff on the evaluation process for the Weeneebayko Area Health Integration Framework Agreement (WAHIFA) and hospital infrastructure needs.
- **First Nations provider meeting for members of the Sudbury/Manitoulin/Parry Sound Hub:** In November 2014, the NE LHIN hosted a First Nations provider meeting for members of the Sudbury/Manitoulin/Parry Sound hub as well as the Temagami First Nation. More than 14 people participated. The objective was to review reporting requirements for First Nations CSS providers. Accountability agreements were reviewed, timelines for reporting confirmed, and a dialogue ensued regarding the requirements for reporting. In addition, an exchange of options for the delivery of CSS programs was shared amongst providers. Given the positive outcomes, participants now meet twice per year to continue their work and dialogue.

Community Engagement with Francophones

About 23% of people living in Northeastern Ontario are Francophone, and enhancing access to care for them through linguistically and culturally appropriate services is a priority.

The NE LHIN works in partnership with the Réseau du mieux-être francophone du Nord-Est de l'Ontario (RMEFNO) to engage with Northerners to ensure greater access to care for Francophones in their language of choice.

At a day-long workshop on improving patient outcomes through engagement in February 2015, Jonathan Bussières, Data Analysis Coordinator; Chantal Bohémier, Planning and Community Engagement Officer with the RMEFNO; and Cynthia Stables, NE LHIN Director of Community Engagement, shared their common interest of increasing access to care through proactive and culturally sensitive engagements with Northerners.

Engagements held in 2014/15 include:

- The RMEFNO participated in two joint NE LHIN/The Change Foundation patient engagement sessions where HSPs, patients and caregivers learned about programs, services, processes and tools that allow patients to be more involved in system improvements while ensuring an "Active Offer" for French services
- Active participation of Francophones living in Wawa, White River and Dubreuilville as part of the implementation of the NE LHIN's North East Rural Communities Framework
- A community engagement session in Cochrane on solutions to improve access to primary care services for Francophones
- Twelve community-based Francophone tables to identify the needs and priorities of Francophones, which in turn help the RMEFNO advise the LHIN on French Language Services
- Increased awareness of the importance of "Active Offer" across the LHIN through joint communication efforts of the RMEFNO and the NE LHIN
- A Virtual Coffee Break in partnership with the RMEFNO and Ontario's French Language Services Commissioner with more than 80 Northerners participating in a call-in talk-show on the need for HSPs to embrace "French Active Offer"
- Support for active participation of the RMEFNO in various HSP tables across the region to ensure Francophone needs are considered in health care planning activities

Ministry and LHIN Initiatives

Progress Report on the Four NE LHIN Priorities

Priority: Increase Primary Care Coordination

Primary care is the first point of entry to the health care system, focusing on services related to health promotion, illness and injury prevention, as well as the diagnosis, assessment, treatment and management of chronic conditions.

- Primary care providers play a central role in helping patients navigate the system and improve transitions between care settings, particularly for seniors or people with complex needs.
- Greater involvement of primary care providers to improve system integration contributes to a more appropriate use of other care settings by helping people get the right care, in the right place, at the right time.
- Collaboration between primary care and community-based providers helps people living with chronic health conditions and places an emphasis on prevention, coordination and support for self-care.

NE LHIN Goal: Improve access to high quality primary care for Northerners. *Work to date*:

- Health Care Connect helps people find a family health care provider. From February 2014 to February 2015, the percentage of patients successfully connected to a primary care provider was 78%, up from 69% the year before.
- 11% of people in Northeastern Ontario do not have a primary care provider. In 2014/15, a number of communities saw a significant increase in unattached patients due to retiring physicians who were unable to find a replacement physician for their patients. The NE LHIN works with the MOHLTC, the HealthForceOntario Marketing Recruitment Agency, the Northern Ontario School of Medicine (NOSM), and other organizations to assist retiring physicians transition out of practice, as well as to understand how we can best support recruitment and retention efforts.
- Only 29% of Northerners who are sick are able to visit a primary care provider on the same day or the next day, a drop from 34% last year. The NE LHIN is working to promote Health Quality Ontario's Advanced Access to all primary care physicians and primary care organizations, such as FHTs and NPLCs.
- The NE LHIN embraces the use of the Ontario Telemedicine Network (OTN) as a way to increase access to care and is the highest user of telemedicine among the 14 LHINs, with 298 sites. For patients, telemedicine's two-way videoconferencing means care closer to home, less travel, and an increase in the types of care available. Under the leadership of the NE LHIN, the region's number of OTN sites has grown by 423%, from 57 sites in 2006/07.
- The NE LHIN championed the Telehomecare program for patients with COPD and heart failure, to help them learn to self-manage their chronic conditions. Telehomecare nurses teach, coach and enable patients to actively manage their condition, through technology at home. Over 1,400 Northerners have been enrolled in the program.

NE LHIN Goal: Increase integration of primary care in the broader continuum of care. *Work to date*:

- The Physician Office Integration (POI) project put in place the infrastructure needed to send patient reports and results to primary care physicians via their electronic medical records (EMR) system. NE LHIN hospitals have sent over 1.9 million patient discharge summaries, diagnostic

imaging and lab reports to a secure regional repository. About 82% of all family physicians in Northeastern Ontario are using EMR and 95% of EMR users are also part of POI, receiving patient information at discharge from hospital and allowing primary care providers to arrange home care and patient follow-up.

- The NE LHIN Primary Care Advisory Council created a sub-committee to build better linkages between primary care providers and the NE CCAC to ensure continued communications between home care providers, hospital and primary care physicians. The committee worked to develop a system that connects CCAC Care Coordinators with primary care providers. In 2015/16, this work will be mapped out for the community sector, as the NE LHIN implements the *Home and Community Care Sector Act* changes for lower acuity patients.
- Health Links are supporting people by creating individualized plans that wrap personalized care around patients. (Please see page 28 for more on Health Links and integrated models of care underway across the region).

***Crystal Noel** is a primary care nurse practitioner who cares for people, mainly frail seniors who are discharged home from hospital and do not have a primary care provider. Noel provides primary care in the home,which includes comprehensive health assessments, prescribing and monitoring her patients' medications, and referrals to specialists as needed.*

NE LHIN Goal: Engage and collaborate with primary care providers to better support the patient journey. *Work to date*:

- The NE LHIN Primary Care Advisory Council of physicians and NPs meets six times per year to provide feedback on the NE LHIN's planning activities, such as geriatric services and hospice palliative care.
- In November 2014, the NE LHIN engaged with the region's 25 hospitals' chiefs of staff at a Medical Leaders Conference in Sudbury. In addition to a presentation by the NE LHIN CEO, three of its physician leads presented on their work. Dr. Derek Manchuk, Critical Care Lead, spoke about regional Ebola planning and the work of the Virtual Critical Care Unit; Dr. Paul Preston, Primary Care Lead, talked about primary care's role in the system and new ways to improve linkages; and Dr. Gary Bota, Emergency Department Lead, spoke about the importance of putting best evidence practices at the point of care so that busy Emergency Department (ED) doctors can use them to improve patient outcomes.
- The NE LHIN sends regular communiqués to hospital chiefs of staff to keep them apprised and to provide opportunity for input on system improvements underway.

Priority: Enhance Care Coordination and Transitions to Improve the Patient Experience

- This priority focuses on improving the patient journey within the health system by enhancing the coordination and transitions of care between individual HSPs, organizations and sectors. This is particularly true for the frail elderly and/or individuals with complex medical conditions.
- Enhanced care for our growing seniors' population is a focus that weaves its way through each of the LHIN's priorities. The NE LHIN continues to facilitate change with providers to ensure seniors and the frail elderly benefit from a more coordinated continuum of care.

NE LHIN Goal: Improve access and quality through greater service coordination. *Work to Date:*

- Continued investments in care coordinators, and patient and system navigators will help people find the right care at the right time. The NE LHIN provides the Canadian Mental Health Association (CMHA) Sudbury/Manitoulin with funding to support a patient navigator program that diverts people from the ED. Similar diversion programs are also underway in North Bay, Sault Ste. Marie and Timmins.
- North Eastern Ontario Joint Assessment Centres (NE JACs) provide more care options for people suffering from hip and knee ailments. NE JACS have completed more than 19,000 assessments on Northerners, finding 69% of patients do not require a surgeon's consultation as their symptoms can be well managed without surgery. The success of the program has led to the expansion to now include shoulders.
- More coordination of group hospital purchases and shared services, such as pharmacy, is enhancing the level of care smaller hospitals provide while supporting more efficient operations.
- The NE LHIN worked with the NE CCAC and rural northern communities to identify and implement initiatives to strengthen homecare service delivery through partnership with local HSPs. Occurring in a phased-in approach, local teams are formed in each community to ensure that initiatives are based on the specific needs of the respective community, and that the appropriate local stakeholders have the opportunity to participate in the process. Phase 1 (underway) includes the communities of Hearst, Kapuskasing, Smooth Rock Falls, and Chapleau. Other communities across the region will be approached for phase Phases 2 and 3 over the next year.
- The NE LHIN worked with the CSS sector to develop a "mini-site" on the North East Healthline website, and ensured provision of records in French.

NE LHIN Goal: Improve client transitions between HSPs along the continuum of care. *Work to Date:*

- The NE LHIN invested in a regional approach to 'patient order sets' (an electronic software tool of checklists) for 24 hospitals to support increased quality of care for patients. Order sets are being implemented for hip fractures and COPD to ensure patients get the appropriate treatment based on evidence and best practices.
- Initiatives were implemented to support more senior friendly hospitals through the implementation of Senior Friendly Hospital Improvement Plans.
- Innovative programs like PATH (Priority Assistance to Transition Home), which is a partnership between hospital and the Red Cross, is helping to smooth the transition out of hospital to home for discharged elderly patients. The program exists in Espanola, Parry Sound, North Bay and Sudbury, and in the past two years, more than 1,800 senior clients have been served by PATH, with 390 diversions from hospital.
- The Rapid Response Nursing Program is enabling effective transitions between hospital and home for patients with chronic disease. .
- The NE LHIN worked with Community Care Information Management to expand Integrated Assessment Records in LTCHs. This application allows authorized users to view multiple community-based assessments for a single patient.

NE LHIN Goal: Enhance targeted service capacity where required. *Work to Date:*

- The NE LHIN advanced quality palliative care through the leadership of the North East Hospice Palliative Care Steering Committee, which brings regional stakeholders together to oversee implementation of the province's policy document, *Advancing High Quality and High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action* (2011). The Steering Committee is working to increase access to residential hospice beds in the North East by ensuring the residents of each district have access to the minimum number of beds set by the population-based bed ratio. It is also working to strengthen and optimize hospice volunteer visiting services and enhance palliative pain and symptom management strategies for all sectors.
- The NE LHIN will begin funding the Algoma Shared Care Team in 2015/16, a team of palliative care experts available 24/7 to assist primary care providers in supporting their patients dying at home, in retirement home, in LTC and in residential hospice.
- More one-on-one home-based physiotherapy services in home and LTC settings was provided as well as a significant increase in the number of physiotherapy clinics (from two to 16). Physiotherapy services are now available in four large cities and 16 smaller communities.
- The NE LHIN funds two types of classes offered free to older adults: 177 seniors' exercise classes and another 111 locations for falls prevention classes across the region. It is estimated that 1,700 Northerners have benefited from these classes.
- The NE LHIN supports the innovative Virtual Critical Care program that extends the reach of expert providers to critically ill patients in our region's community hospitals.
- The NE LHIN expanded North East Specialized Geriatric Services (NE SGS) to improve access to geriatric care with 750 new referrals to the program (both at the main clinic in Sudbury and through outreach clinics across the region). The NE SGS is instrumental in supporting memory assessment training for primary care practitioners across the region.
- Assisted living services for older adults were expanded – close to 1,500 high-risk seniors are now provided with assisted living services including personal care, case management, and light homemaking.
- Between June 2013 and June 2014, the NE LHIN led a review of non-urgent inter-facility transfers across the region. The review responds to concerns by patients, hospitals and EMS workers regarding the impact of the region's growing seniors' population on the sustainability of how patients are currently transferred to and from hospitals for non-urgent matters. Patient delays for return trips from appointments, patient flow blockage at hub hospitals, and stranding of patient escorts after they accompany patients to other hospitals were a few of the issues raised. Since the completion of the review, the NE LHIN supported an interim non-urgent patient transportation governance structure, worked with Health Sciences North on a service tendering process, and worked with all stakeholders on defining a multi-year funding strategy for the new model.

Diane Morin of New Liskeard laces up her shoes in preparation for attending NE LHIN-funded exercise classes in her community. The LHIN's efforts have supported 111 new falls prevention exercise classes, which complement the 177 free public exercise classes for seniors across the region.

Priority: Make Mental Health and Addictions Treatment Services More Accessible

- There can be no health without mental health.
- This priority fits well within the second phase of the MOHLTC's Mental Health and Addictions Strategy, which sets out five pillars for achieving better mental health and addictions recovery: (1) Promote resiliency & well-being in Ontarians; (2) Ensure early identification & Intervention; (3) Expand housing, employment, supports and diversion and transitions from the justice system; (4) Right service, right time, right place; and (5) Fund based on need and quality.
- In 2015, there are just over 99,000 people in the NE LHIN region living with a mental health or addictions diagnosis.

NE LHIN Goal: Improve access and system navigation for consumers and their families. *Work to date:*

- A mental health and addictions central intake and referral service was implemented in Algoma.
- The NE LHIN participated in a community mobilization table across the region, including a specific Aboriginal centralized program operated by the North Shore Tribal Council.
- NE LHIN staff worked with community partners to expand the hours of peer support services like "Hope House" in Sault Ste. Marie, to provide evening and weekend options to individuals who need support during "off" hours.
- Funding for the training of peer support workers in Sudbury through the Northern Initiative for Social Action (NISA) was provided.
- A community mobilization table in Sudbury and North Bay was established to help support at-risk consumers.
- The NE LHIN provided increased consumer peer support and enhanced case management to the Mattawa area.

NE LHIN Goal: Increase community capacity to provide more care options for Northerners while decreasing acute sector pressures. *Work to date:*

- The NE LHIN worked with community partners to develop a Managed Alcohol Program (MAP) in Sudbury to provide intensive supports to people with chronic alcohol addiction issues who otherwise would be presenting themselves at the ED.
- A Rebound Program (a youth addiction prevention program) in two communities – Sault Ste. Marie and Sudbury was implemented with one in Sudbury, based at an AHAC, focusing on supporting urban aboriginal youth.
- The NE LHIN worked with the Centre for Addiction and Mental Health's telepsychiatry program to team up a number of FHTs with a psychiatrist to provide consultative and educational support to the teams.
- Support for the expansion of hours and space for the Phoenix Rising Woman's drop in centre Sault Ste. Marie was provided.

NE LHIN Goal: Enhance care supports for people with complex issues through increased collaboration. *Work to date*:

- The NE LHIN worked with the MOHLTC, community mental health providers and municipal housing representatives to establish housing options and supports for individuals with mental health and addictions issues across the region.
- New housing for consumers with acquired brain injury was established in North Bay.
- Support to the Community Counselling Centre of Nipissing was provided to assist with the establishment of a regional Postpartum Mood Disorders Network and promotional materials.
- The NE LHIN invested in a transitional case management model in Algoma and Sudbury/Manitoulin to help individuals transition from hospital back into the community, and also support consumers to help them maintain their housing within the community.

- Partnership efforts between the NE LHIN, hospitals, community mental health providers and police services have now yielded effective crisis teams in Sudbury and North Bay. In Sudbury, the Community Crisis Model was created through partnership with Health Sciences North, the CMHA Sudbury/Manitoulin and the Greater Sudbury Police Services, and crisis intervention services moved from the hospital to a downtown location, the mobile program and office hours were enhanced, and all police received mental health training. Crisis usage has increased tri-fold from just under 400 visits a quarter to 1,200, while police apprehensions have fallen by more than 20%. In North Bay, the model was created through a partnership with the North Bay Regional Health Centre (mental health and addictions community programs) and the North Bay Police Service. From September 2014 to March 2015, data shows a 30% reduction of individuals brought to the ER under apprehension; more than 250 hours spent serving clients in the community rather than in hospital; a 50% reduction in time spent by police in the ER; and more than 40 new service linkages made.

Chantale Michaud, Peer Support Specialist (left); John Bowcott, Executive Director, People for Equal Partnership in Mental Health (PEP); Carol Philbin Jolette, Senior NE LHIN Officer; and Mary Davis, Executive Director of Nipissing Mental Health Housing and Support Services are shown at the opening of a new Mattawa location for PEP in May 2015. In March 2015, the NE LHIN announced a total of $4.4 million for projects and services including mental health peer support, care for people with acquired brain injuries, housing support, expanded forensic mental health services for women, and help for parents through the launch of a Northern Ontario Postpartum Mood Disorders Network strategy across the Northeastern Ontario region. PEP peer support now provides recovery-oriented programs for 100 new clients in Mattawa and surrounding area.

Priority: Target the Needs of Culturally Diverse Population Groups

Aboriginal

The NE LHIN continues to support the advancement of Aboriginal/First Nations/Métis health initiatives to enhance access and improve coordination of health programs and services for Aboriginal people. The NE LHIN relies on the expertise of its LAHC, which advises the LHIN Board of Directors on health service priorities and opportunities for engagement and better coordination of services within Aboriginal/First Nations/Métis urban and rural communities.

NE LHIN Goal: Enhance access to health care services that are linguistically and culturally appropriate. *Work to date:*

- The NE LHIN provided on-line training for 164 participants in Indigenous Cultural Competency, including NE LHIN staff and HSP staff.
- NE LHIN staff cooperated with stakeholders and staff from BSO to develop and implement an Aboriginal North East BSO strategy.

NE LHIN Goal: Increase system navigation, service coordination and access to care. *Work to date:*

- The NE LHIN supported First Nations-specific assisted living for high risk seniors programs: Maamwesying North Shore Community Health Services; 15 high risk seniors from seven First Nations communities across the North Shore; 10 high risk seniors from Nipissing First Nation; and five high risk seniors from Moose Cree First Nation.
- Planned and coordinated additional specialized geriatric clinics with local partners were established. Geriatricians and allied health professionals spent three days in Moosonee and Moose Factory and assessed 117 elders: 41 geriatric assessments, 22 full diabetic assessments, and 45 chiropody assessments. Some patients received assessments from all three disciplines.

The NE LHIN partnered with the Red Cross to provide culturally appropriate PSW training in First Nation communities along the James and Hudson Bay Coasts, resulting in 15 PSW graduates.

- The NE LHIN supported First Nations providers to be trained and provide exercise and Stand Up! programs in their communities.

NE LHIN Goal: Increase access to mental health and addictions services. *Work to date:*

- The NE LHIN worked to create a seamless continuum of care through membership on committees for Health Service Integration Fund Projects at Maamwesying North Shore Community Health Services, United Chiefs and Councils of Mnidoo Mnising, and WAHA.
- NE LHIN staff worked in partnership with Health Canada and MOHLTC to support community wellness development teams at Ngwaagan Gamig Recovery Centre and Sagashtawao Healing Lodge, which provide expertise and planning support to First Nations communities seeking assistance in addressing prescription drug abuse and the underlying mental health issues that impact substance abuse and addiction.
- With NE LHIN support, the Benbowopka Treatment Centre enhanced its capacity for treatment of complex clients with opiate/drug withdrawal and follow up aftercare services allowing the treatment centre to better meet the needs of clients by shifting to a harm reduction model. Further support was provided for OTN equipment to facilitate consultations and allow patients to connect with family.
- With NE LHIN support, the Maamwesying North Shore Community Health Services was able to increase capacity and create coordinated access through centralized intake.

Francophone

The NE LHIN currently has 40 HSPs officially designated under the *French Language Services Act* and has identified 58 other providers who are planning for the provision of French Language Services (FLS). In partnership with the French Language Health Planning Entity (FLHPE), the NE LHIN has worked to increase access to health care services in French by actively working with providers to develop designation submissions and ensure that the needs of Francophones are considered in all LHIN planning activities.

NE LHIN Goal: Enhance access to health care services that are linguistically and culturally appropriate. *Work to date:*

- Training and support was provided to the FLHPE staff on FLS designation process and criteria.
- The NE LHIN supported the development of designation requests, receiving two new designation requests this year from Maison Vale Hospice and CMHA – Nipissing Regional Branch. Three other providers are actively working on their designation submissions.
- With the assistance of the FLHPE, an Active Offer toolkit was developed and shared with 10 providers. In addition, the FLHPE provided a presentation on Active Offer to providers and also presented at two NE LHIN patient engagement forums.

A new seniors' day program began offering programs two days per week in Verner. "It's fun to come here," Marc Côté said during a break from a challenging crossword game in French held with the entire group in Verner, including his wife, Flore (shown together in photo).

NE LHIN Goal: Increase system navigation, service coordination and access to care. *Work to date:*

- Considering that about 70% of the population covered by the North Cochrane Health Link is Francophone, collaborating partners have been engaged throughout this process to ensure that the needs of this substantial population are taken into consideration at every stage.
- With NE LHIN funding, two FLS designated providers were able to enhance access for Francophones for an additional 13 assisted living clients.
- The NE LHIN funded another FLS designated provider, the Alzheimer Society of Sudbury – Manitoulin – Nipissing, for a First Link Coordinator for the Nipissing area.

NE LHIN Goal: Increase access to mental health and substance abuse services. *Work to date:*

- In Sudbury, the integration of three addiction programs, one of which is designated, will enhance planning for FLS.
- The CMHA Nipissing Regional Branch submitted its designation plan.
- The CMHA Sudbury/Manitoulin, a designated provider, received funding to enhance mental health services. This will include services to the Francophone population.

Priority Enablers

Three system enablers help to advance our IHSP's four priorities. The following three pages provide information on additional work taking place within each enabler.

Realignment and System Transformation

There are many initiatives being implemented in Northeastern Ontario in an effort to rebalance the health care system to provide more focus on patient-centred care and care available in community or at home.

Clinical Services Review

With the completion of the Clinical Services Review, the 2014/15 focus is on implementing two quality based procedures for hip fracture and COPD. Working groups with representation from the four large hospitals and Parry Sound and the NE CCAC began implementing the recommendations for these two quality based procedures. The groups have completed a mapping of their current state and compared it to the best practices outlined in the clinical handbooks. Standard patient order sets have been implemented across the region, which will allow hospitals to measure their compliance with the handbooks and ensure consistency and quality of care. A common scorecard is being developed which will help measure successes.

Health Links and other Integrated Models of Care

The NE LHIN continues to work with HSPa on a range of integrated models of care.

In smaller communities, the NE LHIN is looking at community networks as a model to integrate care. The recent expression of interest for integrated funding models resulted in six proposals being submitted to the MOHLTC for consideration in 2015/16.

The Timmins Health Link is led by the Timmins Family Health Team and is focused on the creation of a sustainable change management plan that will help shift how the local health care system addresses the needs of its highest users. The Health Link is looking to implement new processes to facilitate communication among providers, particularly with the patient's circle of care.

The Temiskaming Health Link is led by the Centre de santé communautaire du Témiskaming and is focused on system transformation and coordinated care planning. In 2014/15, all partner agencies of the Health Link came together with board chairs to discuss common goals for the district, with the aim of creating one health system score card for the district.

A third Health Link in North Cochrane includes the communities of Hearst, Kapuskasing and Smooth Rock Falls. The Centre de santé communautaire de Kapuskasing and the Équipe de santé familiale Nord-Aski are co-leads. The business plan outlining the care model was completed in March 2015.

Three new Health Links were established in Sault Ste. Marie, Sudbury and Nipissing. The Nipissing Health Link is led by West Nipissing General Hospital and began work to identify high user patients, with the expectation of completing a business plan in June 2015. The Sudbury Health Link, led by the CMHA, is focusing first on mental health and addictions patients in its planning, with the goal of completing its business plan in June 2015. The Sault Ste. Marie Health Link is identifying the appropriate lead agency to move the Health Link forward, and began work on patient identification.

The NE LHIN developed a model of care to address the many communities with a population of less than 50,000. The ***Community Network Model*** provides coordinated care for all residents in a community and includes health and non-health providers. The goal is to develop care pathways based on the needs of the community and to develop stronger linkages among community providers.

A framework was also developed to assess health care needs in smaller communities. The ***North East Communities Framework for Health System Improvement*** provides rural communities with a process to determine where and how improvements can be made within the local health system. Wawa is the first community to pilot the framework. A steering committee, co-chaired by a senior resident and the Red Cross, developed terms of reference and is working through the process to determine the current providers and healthcare needs.

Vision Care Plan

The ***North East Vision Care*** plan was finalized in September 2014 and a steering group began working on implementing the recommendations. The group has both administrative and clinical representatives from the four large hospitals. The group's focus is on recruitment/access to care/repatriation of volumes and compliance with the clinical handbooks for cataract surgery. Standard patient order sets have been implemented and the group meets monthly to determine volumes and recruitment opportunities.

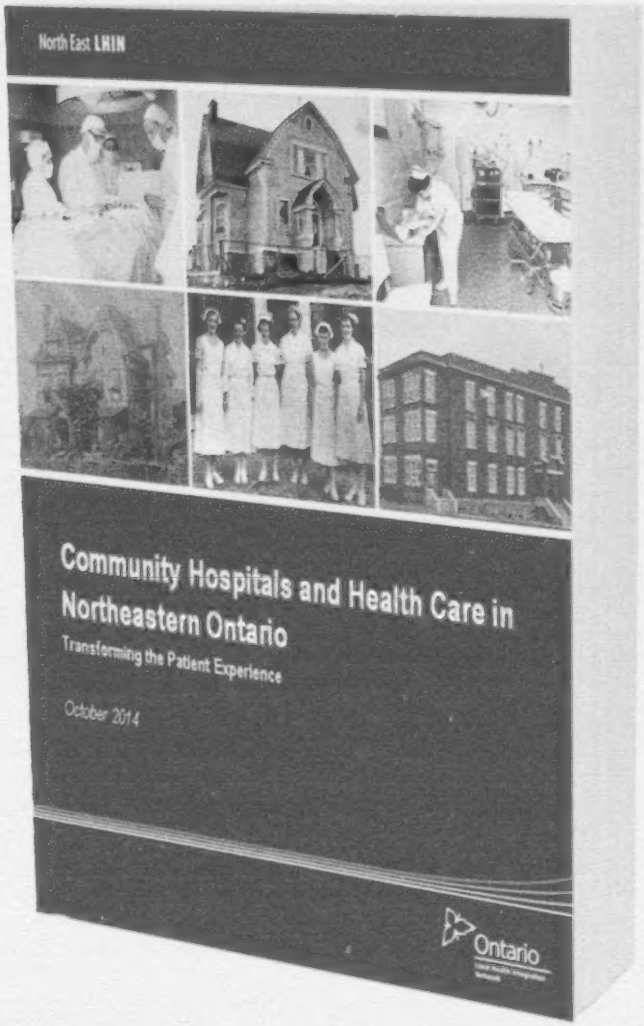
System Integration

Providers across the NE LHIN continue to look for integration opportunities to improve operations and service delivery. In 2014/15, Englehart and District Hospital and the Kirkland and District Hospital entered into a volunteer integration in the form of a partnership agreement at the executive and management levels. Through the partnership, the hospitals will jointly manage the health services that are currently provided, while planning together for the future, with the hiring of a single Chief Executive Officer for both organizations.

Work with Community Hospitals

In 2014, the NE LHIN collaborated with hospitals to research and publish a historical overview of the region's hospitals, with an emphasis on moving forward to create a community model of care that better responds to the needs of the people of Northeastern Ontario.

Community Hospitals and Health Care in Northeastern Ontario: Transforming the Patient Experience invites readers to consider how community hospitals can and should further transform to meet the needs of Northerners today and tomorrow. In support of this effort, the NE LHIN is reviewing community hospitals' trends: analysis for episodes of care and activity levels, financial performance over time, financial performance over time, demographics and health of population served and comparisons to other small hospitals in the NE LHIN region.



Electronic Health Record (EHR) Opportunities

The overarching goal of NE LHIN EHR efforts is: one patient, one record. This means a single point of access for services, patients telling their story only once, and service providers securely accessing and sharing health information electronically while upholding patient privacy. EHRs and Information & Communication Technology (ICT) are key enablers to achieve goals of all LHIN priorities.

ICT solutions are leveraged to support service integration and the delivery of quality patient-focused care. ICT projects reap the greatest benefit when they enhance patient care services or help those who are transitioning through and across systems and sectors; are part of a broader regional strategic ICT plan; use a multi-LHIN, multi-agency or multi-sector partnership approach; have a sound business case; and are used as foundational elements in the creation of an EHR.

More than 76% of physicians in Northeastern Ontario are using EHRs to more quickly access patient files. The NE LHIN continues to work with partners to use technology to strengthen health care in Northeastern Ontario through a variety of initiatives, including the following:

- The NE LHIN rolled out a patient-focused project which matches clients from acute care to the most appropriate level of care, through a standardized provincial electronic referral form. Known as ***Resource Matching and Referral (RM&R)***, the system is intended to provide seamless and efficient client transitions for patients waiting for discharge. RM&R was implemented between the NE CCAC and LTC; between eight hospitals to the CCAC; and all hospitals are using the standardized form for complex continuing care and rehabilitation.

- eConsult, which occurs when a primary care provider electronically sends a question to a specialist, was implemented. This can be a simple question (e.g., about a drug dosage) or a more complex question following an initial assessment by the primary care provider (e.g., asking for a virtual dermatology assessment and providing images of the patient). eConsults may avoid the need to physically send a patient to a specialist for diagnosis or treatment.

- Twenty-two of 24 hospitals have implemented Ontario Lab Information System (OLIS), which gives providers access to provincial lab information for a patient.

- Twenty-four hospitals are using eNotification, new technology that notifies the NE CCAC when a patient is admitted to hospital and notifies hospitals that a patient is receiving home care services, smoothing patient transitions and enhancing quality patient care.

- After broad consultations with community support service agencies, the NE LHIN developed an ***Information and Communication Technology Plan*** that focuses on simplifying client access to CSS. The plan outlines 10 project recommendations and three are actively underway.

Health Human Resources (HHR)

People working to provide health care services are essential to the transformation of our health care system, whether they are treating people while in hospital, or helping them to transition back home. Greater access to health care professionals helps to promote healthy living and support better management of chronic conditions.

A healthy system of care relies on professionals working to their full scope of practice. Recruitment and retention of health care professionals, such as NPs and personal support workers (PSWs), help to ensure a good mix of professionals across the continuum of care. The NE LHIN works with partners to decrease gaps in the mix and distribution of health care professionals, and to ensure a collaborative approach to recruitment and retention strategies.

In the past year, the NE LHIN worked closely with: HealthForceOntario, inviting its staff to interact with the LHIN's senior management on a regular basis and attend our Board's Health Professionals Advisory Committee and Primary Council meetings; and NOSM, actively participating on an HHR subcommittee of the NOSM Teaching Hospital Council.

The NE LHIN also worked with the Nursing Secretariat to provide feedback on the Grow Your Own Nurse Practitioner application for vacant NP positions, an initiative which supports a registered nurse (RN) to receive a NP designation when committing to return to an underserviced community to provide primary health care services.

The NE LHIN co-chaired the Registered Nurses' Association of Ontario's (RNAO) Rural, Remote and Underserviced Area – Nursing Workforce Task Force, looking for solutions to ensure a stable and sustainable workforce exists in rural, remote and underserviced areas of Ontario.

With many primary care physicians at or nearing retirement, the NE LHIN has focused its efforts in the past year on better understanding issues related to new physicians taking over existing practices in order to mitigate orphaned patients. This work has included support from NE LHIN's Primary Care Physician Leads in understanding current capacity of primary care in our communities, and beginning work on future capacity for the system.

The NE LHIN supports education efforts across many sectors. Laurentian University's School of Nursing is in the process of updating its curriculum and the NE LHIN took the opportunity to provide suggestions around fundamentals of palliative care. There are a lot of educational activities occurring in LTC, often only to existing staff; however, many colleges now include standardized B training such as Gentle Persuasive Approach to all PSW students. As well, placement opportunities with colleges and LTCHs have further increased the recruitment and retention of PSWs, RNs, registered practical nurses (RPNs), and Physician Therapy Assistants (PTAs) into LTC.

Other unique programs within the NE LHIN have helped draw new health care professionals to the North. For example, the NE SGS program has recruited a geriatric specialist and encouraged other physicians to work towards getting this designation to support seniors. Geriatric Assessor training allows professionals in many designations to increase their scope of practice. The Emergency Department Outreach Service at Health Sciences North in Sudbury recruits specialized nurses to visit residents in LTCHs requiring acute care that would normally require a visit to the ED, ensuring these residents have access to timely, high quality care within the comfort of their LTCH. The program also minimizes avoidable ED visits.

Stephanie Pilkey, RN; Anick Bureau, PSW; and Stephanie Renaud, PSW provide care to a patient at West Nipissing General Hospital. The NE LHIN created a report entitled Health Human Resources: Today's Northeastern Ontario Landscape and a Forecast for Transformation-Related Capacity. The report was prepared to assist the LHIN and its partners in moving forward with HHR work in NE Ontario. It outlines challenges and strategies to bolster HHR recruitment and retention, and includes a review of data sources and opportunities to gain a better understanding of forecasted vacancies by sector.

Key Provincial Priorities

Alternate Level of Care (ALC) Strategies and Solutions

Patients designated as ALC have needs that are better met in alternate settings such as LTC, rehabilitation, assisted living or home. Having more home care and community services enables ALC patients to leave hospital sooner, live independently in their setting of choice, and make more beds available to patients who are waiting to be admitted to hospital for acute care.

Five years ago, the rate of ALC patients in our hospitals was greater than 30%. In 2014/15, it is down to 22%.

HSPs remain fully engaged through a number of local ALC working groups across the region that tie into a multi-sectoral regional leadership committee.

The NE LHIN continues its focus to help bring down the rate of ALC patients by enhancing community investments and building community capacity such as: home first, additional assisted living for high risk seniors, further expansion of the PATH program, integrated discharge planning, assess and restore programming, behavioural supports for LTCHs, and adult day program expansion. For more information on ALC, please see page 14.

Joan Atkinson is helped by her daughter, Dayle King, after a stay at the North Bay Regional Health Centre. The NE LHIN has been working to help transition older adults from hospital to community by funding programs like PATH. PATH care workers help discharged patients, mainly older adults, by escorting them home, as well as picking up medications and groceries on the way, and linking seniors to services available in community. The first few hours following discharge can be a daunting time for seniors and programs like PATH help to make that easier, safer and more enjoyable.

Emergency Department (ED) Wait Times

The region's four Hub hospitals continue to participate in the provincial ED Pay for Results program which supports a range of ED performance projects. Although there is a degree of variability among the hospitals' performance, the region's overall ED performance is close to or below provincial wait time targets for non-admitted ED patients. Overall, NE LHIN ED wait times performance for admitted patients is an area for improvement related to issues of community capacity and ED volume increases.

Pay for Results initiatives, which have demonstrated success in the North East hospitals include: ED triage nurses, a clinical decision unit, patient flow navigators, an admission avoidance coordinator, geriatric emergency nurses, and mental health programming in the ED. For more information on ED wait times, please see page 13.

Government Investment Increase to Home and Community Services

The NE LHIN continues to make targeted investments to provide more programs and services to allow people to be cared for at home or in community and only in an institution when needed. In 2014/15, the NE LHIN flowed about $291 million to fund community services. In 2009/10, our total funding for community programs was $216 million, representing a 35% increase in funding to this sector.

With approximately 111 community-based service providers in the North East, patients being discharged from hospital (or who are otherwise seeking services in the community) are challenged to navigate a broad range of services, catchment areas, and eligibility requirements. As noted on pages 22 to 23, the NE LHIN has several initiatives underway to help enhance coordination and transitions to community or home-based care to improve the patient experience.

Regionally-Coordinated Diabetes Care

As of June 2014, the NE LHIN had 66,603 people living with diabetes. This represents 14.3% of the LHIN's population and is the highest rate in Ontario. Diabetes education and care are key priorities for the region with the purpose of improved coordination, standardization of practices and maximizing utilization, as well as streamlining accountability and oversight for 21 adult and four pediatric Diabetes Education Programs.

Over the past year, the NE LHIN has worked with HSPs to develop and implement several initiatives to improve the coordination and delivery of diabetes education programs:

- The continued clinical diabetes leadership of Dr. Boji Varghese (Endocrinologist) and Barb Kiely (Primary Care Nurse Practitioner and Certified Diabetes Educator)
- North East Regional Diabetes Advisory Committee with multi-sector representation including patient representatives
- Community of Practice for diabetes educators and providers to network to collaborate and share best practices
- Engagement with primary care providers to review current clinical practice guidelines for diabetes and update on local expertise and services available
- Adoption of pan-provincial standardized policy and reporting procedures
- Support for establishment of an Inpatient Diabetes Nurse pilot at Health Sciences North to enhance care coordination and transitions
- Increased access to evidence-based foot assessments and care for people living on the James and Hudson Bay Coast via chiropody outreach clinics

Analysis of LHIN Operational Performance

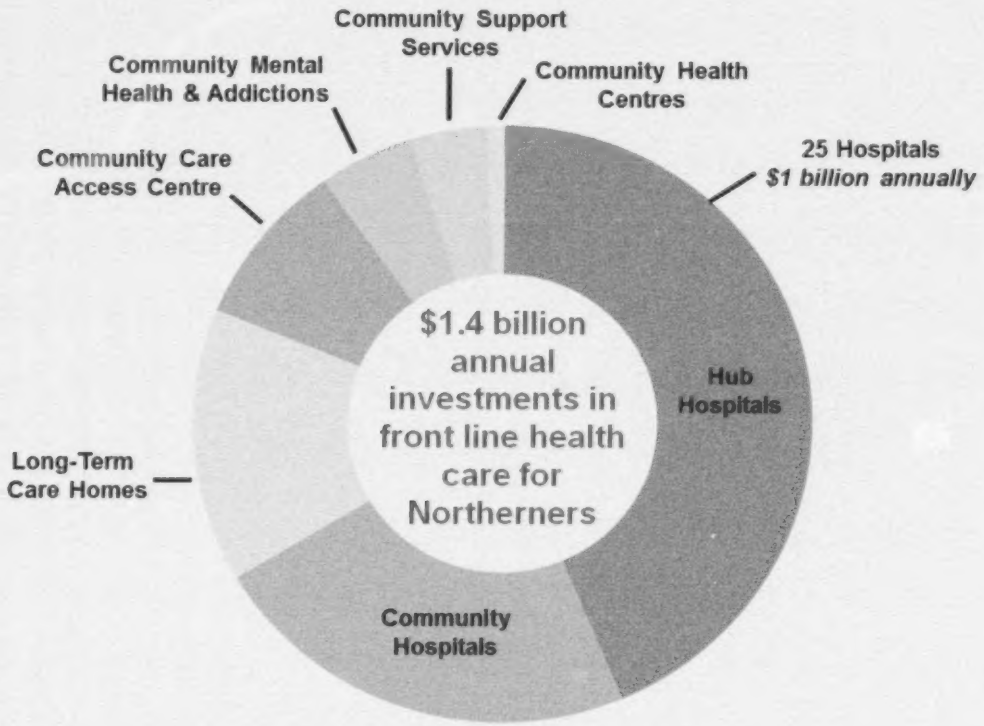
The NE LHIN ended the 2014/15 year with a balanced position. In 2014/15, the NE LHIN provided $1.4 billion dollars to 144 HSPs who deliver more than 200 programs and services across Northeastern Ontario.

The NE LHIN is one of the largest of 14 LHINs, coordinating care for 565,000 people across an estimated 400,000 square kilometres.

The establishment of local offices in North Bay, Sault Ste. Marie, Sudbury and Timmins has enabled the NE LHIN team to meet regularly with local stakeholders. Through the negotiation and monitoring of accountability agreements with health care partners, the NE LHIN is able to direct funding to initiatives to improve patient care and advance a more integrated and efficient delivery of services at the community level.

The NE LHIN has established seven clinical leads with a focus on critical care, EDs, primary care and chronic disease management. In 2014/15, the NE LHIN was successful in recruiting primary care leads in Cochrane, North Bay and Sudbury. Their contribution and insight are assisting the NE LHIN in making decisions to improve the quality of care and enhance access to care for Northerners.

Funding by Sector, 2014/15



25 Hospitals

40 Long-Term Care Homes

46 Community Mental Health & Addictions

67 Community Support Services

6 Community Health Centres

1 Community Care Access Centre

Financial statements of

North East Local Health Integration Network

March 31, 2015

North East Local Health Integration Network

March 31, 2015

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Independent Auditor's Report

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the accompanying financial statements of the North East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2015, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2015, and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
June 10, 2015

North East Local Health Integration Network

Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	319,024	947,565
Accounts receivable	17,158	1,223
HST receivable	35,137	63,318
Due from MOHLTC-Health Service Providers ("HSP") (Note 7)	3,485,239	4,869,191
	3,856,558	5,881,297
Liabilities		
Accounts payable and accrued liabilities	402,456	1,010,911
Due to MOHLTC (Note 10b)	-	15,090
Due to the LHIN Shared Services Office (Note 3)	7,438	4,955
Due to Health Service Providers ("HSP") (Note 7)	3,485,239	4,869,191
Deferred capital contributions (Note 4)	186,407	304,807
	4,081,540	6,204,954
Net debt	(224,982)	(323,657)
Commitments (Note 13)		
Non-financial assets		
Prepaid expenses	38,575	18,850
Tangible capital assets (Note 5)	186,407	304,807
	224,982	323,657
Accumulated surplus	-	-

Approved by the Board

Director

Director

The accompanying notes to the financial statements are an integral part of this financial statement.

North East Local Health Integration Network

Statement of operations
year ended March 31, 2015

	Budget (Note 6)	2015 Actual	2014 Actual
	$	$	$
Revenues			
MOHLTC funding			
HSP transfer payments (Note 7)	1,427,511,500	1,456,998,541	1,466,699,913
Operations of LHIN	4,752,782	4,735,727	4,539,109
Project Initiatives			
Enabling technologies	-	510,000	580,000
French Language Health Service	296,800	296,800	296,800
Réseau du mieux-être francophone du Nord de l'Ontario	796,159	796,159	796,159
Emergency Department Lead	-	75,000	75,000
Critical Care Lead	-	75,000	75,000
Aboriginal Engagement	100,000	100,000	100,000
Emergency Room/Alternate Level of Care (Note 9)	-	100,000	100,000
Primary Care Lead	-	75,000	75,000
Diabetes Regional Coordinating Centre	1,087,560	1,087,560	1,097,990
Physiotherapy Reform LHIN Leads	-	-	27,344
Amortization of deferred capital contributions (Note 4)	131,691	135,895	130,648
	1,434,676,492	1,464,985,682	1,474,592,963
Funding repayable to MOHLTC (Note 10)	-	-	(15,090)
	1,434,676,492	1,464,985,682	1,474,577,873
Expenses			
Transfer payments to HSPs (Note 7)	1,427,511,500	1,456,998,541	1,466,699,913
General and administrative (Note 8)	4,752,782	4,735,727	4,534,449
Project Initiatives Note 9)			
Enabling technologies	-	510,000	580,000
French Language Health Service	296,800	296,800	296,800
Réseau du mieux-être francophone du Nord de l'Ontario	796,159	796,159	796,159
Emergency Department Lead	-	75,000	75,000
Critical Care Lead	-	75,000	75,000
Aboriginal Engagement	100,000	100,000	100,000
Emergency Room/Alternate Level of Care	-	100,000	100,000
Primary Care Lead	-	75,000	75,000
Diabetes Regional Coordinating Centre	1,087,560	1,087,560	1,087,560
Physiotherapy Reform LHIN Leads	-	-	27,344
Amortization of tangible capital assets	131,691	135,895	130,648
	1,434,676,492	1,464,985,682	1,474,577,873
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of this financial statement.

North East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2015

	Budget	2015	2014
	$	$	$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	(17,495)	(203,243)
Amortization of tangible capital assets	131,691	135,895	130,648
(Increase) decrease in prepaid expenses, net	-	(19,725)	2,601
Decrease (increase) in net debt	131,691	98,675	(69,994)
Net debt, beginning of year	(323,657)	(323,657)	(253,663)
Net debt, end of year	(191,966)	(224,982)	(323,657)

The accompanying notes to the financial statements are an integral part of this financial statement.

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2015

	2015	2014
	$	$
Operating transactions		
Annual surplus	-	-
Items not affecting cash		
Amortization of tangible capital assets	135,895	130,648
Amortization of deferred capital contributions (Note 4)	(135,895)	(130,648)
Changes in non-cash working capital		
(Increase) decrease in accounts receivable	(15,935)	6,469
Decrease in HST Receivable	28,181	7,586
Decrease (increase) in due from MOHLTC-Health Service Providers	1,383,952	(3,331,538)
(Decrease) increase in accounts payable and accrued liabilities	(409,781)	221,741
Decrease in due to MOHLTC	(15,090)	(204,817)
Increase (decrease) in due to the LHIN Shared Service Office	2,483	(23,200)
(Decrease) increase in due to Health Service Providers	(1,383,952)	3,331,538
(Increase) decrease in prepaid expenses	(19,725)	2,601
	(429,867)	10,380
Capital transaction		
Acquisition of tangible capital assets	(216,169)	(157,093)
Financing transaction		
Increase in deferred capital contributions (Note 4)	17,495	203,243
Net (decrease) increase in cash	(628,541)	56,530
Cash, beginning of year	947,565	891,035
Cash, end of year	319,024	947,565

(See additional information presented in Note 5.)

The accompanying notes to the financial statements are an integral part of this financial statement.

North East Local Health Integration Network

Notes to the financial statements
March 31, 2015

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2015.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at cost. Cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired and brought into use during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Related party transactions

LHIN Shared Services Office, LHIN Collaborative

The LHIN Shared Services Office (the "LSSO") and the LHIN Collaborative (LHINC) are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs, are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portions of the LSSO/LHINC operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable from (payable to) the LSSO/LHINC. This is all done pursuant to the agreement the LSSO/LHINC has with all the LHINs.

Enabling Technologies for Integrated Porject management Office

In fiscal 2014, the LHIN entered into an agreement with the Champlain, South East and North West LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Funding was provided to enable the cluster LHINs Project Management Offices to advance eHealth, information management and information technology initiatives as outlined in the ETI PMO Toolkit Business Case approved by the MOHLTC.

The LHIN's financial statements reflects its share of the MOHLTC funding for ETI PMO for its Cluster and related expenses. During the year the LHIN received of $510,000 (2014 - $580,000).

4. Deferred capital contributions

	2015	2014
	$	$
Balance, beginning of year	304,807	232,212
Capital contributions received	17,495	203,243
Amortization	(135,895)	(130,648)
Balance, end of year	186,407	304,807

5. Tangible capital assets

	Cost	Accumulated amortization	2015 Net book value	2014 Net book value
	$	$	$	$
Furniture and fixtures	215,059	170,583	44,476	61,198
Computer equipment	192,270	173,751	18,519	45,115
Leasehold improvements	1,185,245	1,061,833	123,412	198,494
	1,592,574	1,406,167	186,407	304,807

Non-cash transactions

During the year, tangible capital assets were acquired at an aggregate cost of $17,495 (2014 - $203,243) of which $Nil (2014 - $198,674) were paid after year-end and $17,495 (2014 - $4,569) were paid during the year.

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the statement of operations reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,456,998,541 is made up of the following:

	$
Initial HSP Funding budget	1,427,511,500
Adjustment due to announcements made during the year	29,487,041
	1,456,998,541

The total operating budget of $7,868,301 is made up of the following:

Initial budget	7,033,301
Additional funding received during the year	835,440
Amount treated as Capital Contribution	(17,495)
Total budget	7,851,246

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,456,998,541 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2015	2014
	$	$
Operation of Hospitals	946,543,719	971,964,798
Grants to compensate for Municipal Taxation - Public Hospitals	211,725	240,300
Long-term Care Homes	219,412,436	213,745,487
Community Care Access Centres	132,359,143	132,507,757
Community Support Services	34,785,603	30,498,707
Acquired Brain Injury	2,983,649	2,687,549
Assisted Living Services in Supportive Housing	20,715,195	18,887,538
Community Health Centres	19,352,638	18,718,830
Community Mental Health	57,799,582	55,364,627
Substance Abuse and Gambling Problem	22,834,851	22,084,320
	1,456,998,541	1,466,699,913

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2015, an amount of $3,485,239 (2014 - $4,869,191) was receivable from the MOHLTC and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

8. General and administrative expenses

The statement of operations presents the expenses by function; the following classifies these same expenses by object:

	2015	2014
	$	$
Salaries and wages	2,954,194	2,894,828
HOOPP	277,759	253,264
Other benefits	366,950	335,962
Staff travel	141,368	149,568
Governance travel	11,546	10,629
Communications	144,631	83,962
Accommodation	259,396	237,377
Advertising	6,939	8,460
Consulting fees	80,364	150,611
Equipment rentals	9,876	10,895
Board Chair per diems	9,575	26,625
Other Governance per diems	23,922	8,350
Insurance	6,762	6,137
LHIN Shared Services Office	225,091	138,886
LHIN Collaborative	47,500	47,500
Other meeting expenses	27,685	22,234
Other governance expenses	4,733	8,615
Printing and translation	44,849	61,439
Staff development	38,630	21,334
IT equipment	26,102	28,458
Office supplies and equipment	23,804	24,462
Other	4,051	4,853
	4,735,727	4,534,449

9. Program initiatives

The LHIN received funds for various project initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2015	2014
	$	$
Salaries and benefits	1,814,434	1,809,744
Professional services	220,680	279,000
Shared services	130,000	87,776
Occupancy	73,500	82,393
Public relations and community engagement	38,071	45,895
Supplies	9,042	41,917
Mail, courier and telecommunications	13,450	13,884
Other operating expenses	816,342	852,254
	3,115,519	3,212,863

9. Program initiatives (continued)

Diabetes strategy operational expenses included in the project initiative expenses above are as follows:

	Budget 2015	Actual 2015	Actual 2014
	$	$	$
Salaries and benefits	877,620	877,620	877,620
Other operating expenses	209,940	209,940	209,940
	1,087,560	1,087,560	1,087,560

10. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC is made up of the following components:

	Funding received	Eligible expenses	2015 Excess funding	2014 Excess funding
	$	$	$	$
Transfer payments to HSPs	1,456,998,541	1,456,998,541	-	-
LHIN operations	4,735,727	4,735,727	-	4,660
Amortization of capital assets	135,895	135,895	-	-
Enabling technologies	510,000	510,000	-	-
French Language Health Services	296,800	296,800	-	-
Reseau du mieux-etre franophone du Nord l'Ontario	796,159	796,159	-	-
Emergency Department Lead	75,000	75,000	-	-
Critical Care Lead	75,000	75,000	-	-
Aboriginal Engagement	100,000	100,000	-	-
Emergency Room/Alternate Level of Care	100,000	100,000	-	-
Primary Care Lead	75,000	75,000	-	-
Diabetes Regional Coordination Centre	1,087,560	1,087,560	-	10,430
Physiotherapy Reform	-	-	-	-
	1,464,985,682	1,464,985,682	-	15,090

b) The amount due to the MOHLTC is made up of the following components:

	2015	2014
	$	$
Opening balance	15,090	219,907
Funding recovered by the MOHLTC	(15,090)	(219,907)
Funding repayable to the MOHLTC (Note 10a)	-	15,090
Closing balance	-	15,090

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 49 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2015 was $416,562 (2014 - $384,580) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2014. At that time the plan was fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in the favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due under the building and equipment lease are as follows:

	$
2016	192,171
2017	89,500
2018	63,417
2019	68,000
2020	68,000
Thereafter	204,000
	685,088

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2015 the LHIN had signed Accountability Agreements with all Hospitals, Long-Term Care Home and Community Agencies. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

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